Dr Manohar Sohanpal

Quality Report

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Date of inspection visit: 05/03/2015
Date of publication: 03/09/2015

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Manohar Sohanpal on 5 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing effective, caring, responsive and well-led services. The practice was also rated good for providing services to older people, people with long-term conditions, families, children and young people, as well as working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia). The practice required improvement for providing safe services and the concerns which led to this rating applied to all population groups.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles, with the exception of some areas of training that had not been updated or undertaken, although further training needs had been identified and training planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice was well equipped to treat patients and meet their needs.
- The practice was clean and there were systems to help ensure standards of hygiene were maintained.

Summary of findings

- There was a clear leadership structure and the practice proactively sought feedback from staff and patients, which it acted on.

We saw an area of outstanding practice:

- The practice had worked with two other local practices to employ and provide a team of three specialist nurses and one health care assistant dedicated to supporting and responding to the needs of older patients over the age of 75. The team offered rapid response to meet urgent needs, as well as routine care and support. For example, they were notified and attended when patients were discharged from hospital, to assess and follow-up any additional needs. They had access to the patient records system and were therefore able to keep information accurate and up-to-date, including care plans that were used for these patients. Data we reviewed indicated that unplanned emergency attendance and admissions into hospital had reduced for this age group.

However there were areas of practice where the provider needs to make improvements.

The provider SHOULD:

- Review the training requirements for administration staff in relation to safeguarding vulnerable adults and children.
- Review the training requirements in relation to infection prevention and control for the lead nurse.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. However, improvements were required in relation to some areas of staff training, including safeguarding and infection control.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Most staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. Staff had received annual appraisals that included discussions in relation to their personal development. Staff worked with multi-disciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice highly for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local patient population and engaged with the clinical commissioning group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP, with urgent appointments available the same day. The practice was well equipped to treat patients and meet their needs. Information about

Summary of findings

how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was discussed and shared with staff.

Are services well-led?

Good

The practice is rated as good for being well-led. Staff were clear about the aims and objectives of the practice and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular practice meetings. There were systems to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) had recently become active and meetings had been held, with further dates scheduled. Staff had received regular performance reviews and attended staff meetings and other events.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. It offered proactive, personalised care to meet the needs of the older people in its patient population and had a range of enhanced services, for example, in avoiding unplanned admissions to hospital. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The practice was caring in the support it offered to older people and there were effective treatments and on-going support for those patients identified with complex conditions, such as dementia and conditions associated with end of life care. All patients over the age of 75 had a named GP who was responsible for their care and treatment.

The practice had worked collaboratively with other local practices in the area to employ and provide a specialist community nursing team for patients over the age of 75, who responded to urgent and routine care needs to deliver multi-disciplinary services.

Annual influenza vaccinations were routinely offered to older people to help protect them against the virus and associated illness.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multi-disciplinary package of care.

Annual influenza vaccinations were routinely offered to patients with long-term conditions to help protect them against the virus and associated illness.

Families, children and young people

Good

The practice is rated as good for families, children and young people. Expectant mothers were referred and supported by the midwifery team and the GPs provided full post-natal care and six week baby checks.

Summary of findings

The practice offered contraceptive clinics and advice, as well as sexual health screening and chlamydia testing for young people. There were systems to identify children who may be at risk and safeguarding procedures to help ensure concerns were followed up.

Immunisation rates were higher than the local averages for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of the working age patient population, those recently retired and students had been identified and the practice had adjusted the services it offered to help ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice was responsive in providing care in patients' homes who found it difficult to attend the practice. The practice carried out annual health checks and offered longer appointments if required, for example, for patients who had a learning disability. The practice worked with multi-disciplinary teams in the case management of vulnerable patients and offered information about various support groups and voluntary organisations.

Practice staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of working hours.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for the care of people experiencing poor mental health. The practice had procedures for identifying patients who had mental health needs. Regular checks and reviews were offered and follow-up contact was made where patients had not attended for appointments. The practice adopted a flexible approach in the support it offered, including offering same day

appointments and had supported patients with routine weekly appointments to reduce their anxiety and to monitor their prescribed medicines. The practice also offered in-house counselling sessions on a regular basis.

The practice worked with multi-disciplinary teams and community specialists in providing support to patients with mental health needs and those with dementia, for example, the community mental health team and psychiatric services. Referrals to other services were made, including crisis support when needed.

Summary of findings

What people who use the service say

We spoke with five patients and reviewed 46 comment cards completed by patients prior to our inspection. The patients we spoke with were positive about the services they received from the practice and said they felt the care and treatment was good. Patients told us they had no concerns about the cleanliness of the practice and that they always felt safe. Patients said referrals to other services for consultations and tests had always been efficient and prompt.

Patients were particularly complimentary about the staff, and said they were always caring, helpful and efficient, and that they were treated with respect and dignity.

Patients told us the appointments system worked well for them and that they were able to get same day appointments if urgent, although some comments were less positive in relation to getting through to the practice on the telephone in the mornings. All patients told us they always had enough time with the GPs and nurses to discuss their care and treatment thoroughly and never felt rushed.

The comment cards we reviewed were very positive in all areas, including appointments, staffing, being treated with care and consideration, and having enough time with the GPs and nurses.

We reviewed the comments from the 2013/14 national patient survey and the practice had been rated well in many areas, including 95% of respondents who said that the last time they saw or spoke with a nurse they were good or very good at treating them with care and concern, compared to 90% nationally. Similarly, 89% of respondents said nurses at the practice were good or very good at involving them in decisions about their care, compared to 85% nationally.

Areas for improvement

Action the service SHOULD take to improve

- Review the training requirements for administration staff in relation to safeguarding vulnerable adults and children.
- Review the training requirements in relation to infection prevention and control for the lead nurse.

Outstanding practice

- The practice had worked with two other local practices to employ and provide a team of three specialist nurses and one health care assistant dedicated to supporting and responding to the needs of older patients over the age of 75. The team offered rapid response to meet urgent needs, as well as routine care and support. For example, they were notified and attended when patients were discharged from hospital, to assess and follow-up any additional needs. They had access to the patient records system and were therefore able to keep information accurate and up-to-date, including care plans that were used for these patients. Data we reviewed indicated that unplanned emergency attendance and admissions into hospital had reduced for this age group.

Dr Manohar Sohanpal

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, and a practice manager specialist advisor.

Background to Dr Manohar Sohanpal

Dr Manohar Sohanpal provides medical care Monday to Friday from 8am to 6.30pm each week day and operates extended opening hours from 7.30am on Friday mornings, and until 7.30pm on Monday evenings. The practice is situated in the coastal town of Westbrook, near Margate in Thanet, Kent and provides a service to approximately 3,800 patients in the locality.

Routine health care and clinical services are offered at the practice, led and provided by the GPs and nursing team. The practice has more patients aged between 5 and 18 years than both the local and national averages, although there are fewer children under the age of 4 registered at the practice than the local and national averages. There are a higher number of older people over the age of 85 registered at the practice than the national average, although there are fewer in this age group than the local average for the area. The number of patients in all age groups recognised as suffering deprivation for this practice is slightly lower than the local average, although significantly higher than the national average.

The practice is a single-handed GP provider (male), who employs one male salaried GP, a full-time female practice nurse, and a part-time female health care assistant. There are a total of six administration, secretarial and reception staff, a practice support manager and a practice / business manager.

The practice does not provide out of hours services to its patients and there are arrangements with another provider (the 111 service) to deliver services to patients when the practice is closed. The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities.

Services are delivered from:

150 Canterbury Road

Westbrook

Margate

Kent CT9 5DB

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not received a comprehensive inspection before and that was why we included them.

Detailed findings

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 5 March 2015. During our visit we spoke with a range of staff including two GPs, a practice nurse, four administration staff and spoke with five patients who used the service. We also spoke with nurses from the community 'over 75' team and representatives from the patient participation group (PPG).

Requires improvement

Are services safe?

Our findings

The practice had systems and procedures for identifying, reporting and recording incidents. There were arrangements for monitoring safety, using a range of information. For example, from audits and checks that were undertaken by staff and from comments and complaints received from patients. Staff we spoke with were able to describe their responsibilities in relation to reporting incidents and concerns and told us they knew the reporting procedures within the practice. One member of staff described an incident that had been reported, involving a patient who had fallen outside the practice. An investigation had followed and changes made to the entrance of the building as a result.

We reviewed the summarised incident reports for the previous year and minutes of meetings where these had been discussed.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring incidents and significant events. We reviewed records of significant events that had occurred during the last year and saw that these were discussed at weekly practice meetings. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. All staff, including reception and administrative staff, knew how to raise an issue for consideration at the meetings and said they felt encouraged to do so.

The practice had a system to manage all significant events. We tracked three incidents and saw records were completed in a comprehensive and timely manner and that actions were taken as a result. For example, a review of the procedure used to share results of CT scans with patients.

Reliable safety systems and processes including safeguarding

There were systems and processes to manage safety within the practice, including arrangements for safeguarding vulnerable adults and children who used the services. The practice had policies for safeguarding children and vulnerable adults and these clearly set out the procedures for staff guidance and contact information for referring concerns to external authorities. Both policies reflected the requirements of the NHS and social services safeguarding protocols and staff had signed to confirm they had read them.

Staff told us that there was a GP within the practice who was the designated lead in overseeing safeguarding matters. GPs, nurses and administrative staff we spoke with were knowledgeable in how to recognise signs of abuse in vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of hours. Whilst the training records demonstrated that nursing staff had undertaken safeguarding training to the required levels, administration staff had not undertaken training in either safeguarding vulnerable adults or children, although they were aware of the practice policy and their responsibilities in relation to safeguarding concerns. The GPs had the necessary training (level three) to fulfil their roles in managing safeguarding issues and concerns within the practice.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so that staff were aware of any relevant issues when patients attended appointments, for example, children subject to child protection plans. GPs liaised with social services to share information in relation to concerns that were identified within the practice.

The practice had a chaperone policy. A chaperone is a person who accompanies a patient when they have an examination and we saw that the practice policy set out the arrangements for those patients who wished to have a chaperone. The policy set out the roles and responsibilities of staff who undertook chaperone duties. Administration staff did not undertake chaperone duties, although the practice planned to include them in future training, to provide flexibility in having more staff available for chaperone duties. Patients were made aware that they could request a chaperone, and details were displayed within the practice and in the patient information leaflet. Staff we spoke with confirmed arrangements were made for those patients who requested a chaperone.

Medicines management

Medicines kept at the practice were stored securely and were only accessible to authorised staff. There was a clear

policy for ensuring that medicines were kept at the required temperatures, and described the action to take in the event of a potential failure. Staff told us that they accessed up-to-date medicines information and clinical reference sources when required via the internet and through published reference sources such as the British National Formulary (BNF). The BNF is a nationally recognised medicines reference book produced by the British Medical Association and Royal Pharmaceutical Company.

There were processes to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses and health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of authorised directions and evidence that nurses had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

The practice was clean and tidy and patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. The practice had an infection control policy, which included a range of procedures and protocols for staff to follow. For example, hand hygiene and the management of clinical and hazardous waste.

Staff we spoke with were knowledgeable about their roles and responsibilities in relation to cleanliness and infection control. Personal protective equipment including disposable gloves, aprons and coverings were available and staff were able to describe how they would use these to comply with the practice's infection control policy.

The training records showed that staff had undertaken infection control training, including administration staff. However, the practice nurse who was the named clinical lead for infection control had not undertaken updated infection control training.

The practice had undertaken infection control audits. An action plan had been implemented to monitor identified actions that required follow-up and were discussed in practice meetings, although these were not always recorded.

Treatment and consultation rooms contained sufficient supplies of liquid soap, sanitiser gels, anti-microbial scrubs and disposable paper towels for hand washing purposes. Domestic and clinical waste products were segregated and clinical waste was stored appropriately and collected by a registered waste disposal company. Information in relation to hand washing techniques and sharps injuries was displayed in treatment rooms for staff guidance. Cleaning schedules were kept that identified the cleaning activity undertaken on a daily, weekly and monthly basis and a system was used to manage the cleaning products and equipment.

The practice had considered the risks associated with Legionella (a germ found in the environment which can contaminate water systems in buildings) and had undertaken regular assessments and checks of the water systems.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date and the practice kept a schedule of the tests undertaken. We saw evidence of calibration of relevant equipment, for example, weighing scales, spirometers and blood pressure monitoring devices.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting staff, including protocols for checking qualifications, professional registration and obtaining references. Records showed that recruitment checks had been undertaken when employing staff. For example, proof of identification, qualifications and registration checks with the appropriate professional body.

Requires improvement

Are services safe?

Criminal record checks through the Disclosure and Barring Service (DBS) had been undertaken for staff, where the practice had assessed that this was appropriate to their roles.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to help ensure that enough staff were on duty and arrangements for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff we spoke with said that there were usually enough staff to maintain the smooth running of the practice, although they told us there were times when they felt under pressure due to their workload. When we spoke with the lead GP, they told us they were aware of the increased workload and that there were plans to recruit two additional administration staff. An additional GP had been recruited to join the practice within the next month. Practice meeting minutes showed that this had been discussed and agreed, given the increased patient numbers registered at the practice. Patients we spoke with told us they felt there were enough staff in the practice to support their care and treatment needs.

The practice used regular locum GPs who were sourced directly by the practice. Records showed that appropriate checks were undertaken when recruiting these staff, for example, proof of identification, and professional registration checks with the General Medical Council (GMC).

Monitoring safety and responding to risk

The practice had systems, processes and policies to manage and monitor risks to patients, staff and visitors to the practice. There were health and safety procedures and information was included in the staff handbook and displayed in the practice for staff guidance, for example, a fire safety action plan.

Staff we spoke with told us they used systems to identify and respond to changing risks to patients, including deteriorating health and well-being. Emergency referrals were made for patients who had experienced a sudden deterioration or urgent health problem. GPs and nursing staff described occasions when they had referred patients urgently to other services. For example, the electronic records system identified patients experiencing poor mental health, who may have required urgent support from community mental health specialists, or an urgent appointment with the GP. Repeat prescribing was also monitored for patients with mental health problems and their prescriptions were reviewed more frequently. Attendances at hospital accident and emergency departments were followed-up and in some cases, the GP saw patients on a weekly basis to manage and support their needs.

Arrangements to deal with emergencies and major incidents

The practice had arrangements to manage emergencies. Records showed that all staff had received training in basic life support and information was displayed for staff guidance in dealing with emergency situations, including anaphylaxis. Emergency equipment was available including access to medical oxygen and staff we spoke with knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew where they were kept. There were processes to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety and regular checks of the premises had been undertaken. Records showed that most staff had received fire safety training.

The practice had an emergency and business continuity / recovery plan that included arrangements relating to how patients would continue to be supported during periods of unexpected and / or prolonged disruption to services. For example, interruption to utilities, or unavailability of the premises.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. They used guidance and diagnostic tools available on their computers to access the most up-to-date documents.

The practice also engaged with other local practices within the clinical commissioning group (CCG) and a GP from the practice met on a weekly basis with other GPs to review and discuss local pathways of care, promote co-working opportunities and review updated clinical guidance. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The practice showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. Data showed that the practice was also in line with national prescribing indicators, which included anti-inflammatory medicines.

Management, monitoring and improving outcomes for people

The practice kept registers to identify patients with specific conditions / diagnosis, for example, patients with long-term conditions including dementia, asthma, heart disease, and diabetes. The electronic records system contained indicators to alert GPs and nursing staff to specific patients' needs and any follow-up actions required, including medicine and treatment reviews. Registers were kept under review and meeting minutes demonstrated that information was shared and discussed regarding the health care needs of specific patients, as well as any additional risk factors that may need to be identified on the patient records system. For example, patients with poor mental health had their medicines monitored closely and in some cases, weekly consultations were arranged with the GPs, who prescribed on a weekly basis.

All patients over the age of 75 had a named GP who was responsible for their care and treatment. The practice had also worked with two other local practices to employ and provide a team of three specialist nurses and one health care assistant, dedicated to supporting and responding to the needs of older patients over the age of 75. As well as offering same day rapid response to meet urgent needs, the 'over 75' nursing team provided routine care and support. For example, they were notified and attended when patients were discharged from hospital, to assess and follow-up any additional needs. They had access to the patient records system and were therefore able to keep information accurate and up-to-date, including care plans that were used for these patients. Data we reviewed indicated that unplanned emergency attendance and admissions into hospital had reduced.

The practice had a palliative care register and had regular internal as well as multi-disciplinary meetings to discuss the care and support needs of patients and their families. Quality and Outcomes Framework (QOF) data indicated that multi-disciplinary review meetings were held at least every three months to discuss all patients on the register. QOF is a national performance measurement tool used by GP practices to measure and compare their performance to other practices on a local and national basis.

Data collected for the QOF was reviewed at clinical meetings where information was shared and discussed amongst relevant staff to monitor performance. The available QOF data showed that the practice had overall indicators that were higher than the national averages in many areas. For example, clinical indicators were either in line or considerably higher in areas for patients receiving care and treatment for diabetes. The QOF data also showed that 100% of patients diagnosed with dementia had received a 'face-to-face' review in the last year, compared to the national average of 95%. The practice was not an outlier for any QOF (or other national) clinical targets.

The practice had a system for completing clinical audits. We looked at two clinical audits that had been undertaken in the last year. For example, an audit had been undertaken to identify the number of patients diagnosed with dementia, as the prevalence was lower than expected. Actions had therefore been implemented to improve the assessment protocols for those patients who may be at higher risk. This included setting up alerts on the patient records system, to help ensure GPs were offering dementia assessments and tests, as well as making improvements to the recording system so that patients with dementia were identified correctly on the register. The practice had carried out a further audit to review the impact of the changes

Good

Are services effective?

(for example, treatment is effective)

made and it was found that the number of patients diagnosed with dementia and placed on the register had increased significantly over a six month period. Patients newly diagnosed had been referred to specialist clinics and services for additional support, for example, memory clinics.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP and the computer system provided an alert for those patients who required a medicines review.

Effective staffing

Practice staff included GPs, nurses, managerial and administrative staff. Records showed that staff attended a range of training to help ensure their skills were kept up-to-date, including mandatory courses such as annual basic life support. GPs and nurses had also completed specialist clinical training appropriate to their roles. For example, diabetes, asthma, family planning and updates in childhood immunisations, vaccinations and cervical cytology.

Records confirmed that staff received annual appraisals. All the staff we spoke with felt they received the on-going support, training and development they required to enable them to perform their roles effectively. The practice was proactive in providing training for relevant courses, for example, customer care training for reception / administration staff.

All GPs were up to date with their annual continuing professional development requirements and had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

Working with colleagues and other services

The practice had well established processes for multi-disciplinary working with other health care professionals and partner agencies. GPs and nurses told us these processes helped to ensure that links remained effective with community and specialist nurses, to promote patient care, welfare and safety. For example, monthly multi-disciplinary meetings that included community nurses who specialised in palliative care and had specialist knowledge in long-term and complex conditions, such as respiratory and heart conditions. The practice had systems to help ensure information was shared with appropriate staff so that patient's records were kept up-to-date.

Multi-disciplinary meetings were held to review and discuss the needs of patients over the age of 75, and included the involvement of the community based 'over 75' team of specialist nurses, who held a caseload of older patients referred by the practice.

The practice received blood test results, x-ray results and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had procedures that set out the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well.

Information sharing

Staff told us there were effective systems to help ensure that patient information was shared with other service providers and recognised protocols were followed. For example, there was a system to monitor patients' transition in relation to unplanned / emergency admissions to hospital. A referral system was used to liaise with the community nurses and other health care professionals, including the 'out of hours' service. The practice used the 'Choose and Book' referral system, although GPs told us that most older patients preferred the GP to arrange a letter of referral for them. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice had systems to provide staff with the information they needed. An electronic patient record system was used by all staff to co-ordinate, document and manage patients' care. All staff were fully trained on the system and told us the system worked well. The system enabled scanned paper communications, such as those from hospital, to be saved in the patients' electronic records.

Consent to care and treatment

Good

Are services effective?

(for example, treatment is effective)

The practice had a consent policy that governed the process of patient consent and provided guidance for staff. The policy described the various ways patients were able to give their consent to examination, care and treatment as well as how that consent was recorded.

Staff we spoke with gave examples of how a patient's best interests were taken into account if a patient did not have the capacity to make a decision. Mental capacity assessments were carried out by the GPs and recorded on individual patient records. The records indicated whether a carer or advocate was available to attend appointments with patients who required additional support.

Records showed that Mental Capacity Act 2005 training had been undertaken by one of the GPs, a health care assistant and some of the administration staff in the practice. Staff were aware of the need to identify patients who might not be able to make decisions for themselves and to bring this to the attention of GPs and nursing staff.

Health promotion and prevention

The practice had a system for informing patients when they needed to come back to the practice for further care or treatment or to check why they had missed an appointment. For example, the computer system was set up to alert staff when patients needed to be called in for routine health checks or screening programmes. Patients we spoke with told us they were contacted by the practice to attend routine checks and follow-up appointments.

There was a range of information leaflets and posters in the waiting area for patients, informing them about the practice and promoting healthy lifestyles, for example, smoking cessation, and weight management. Information about how to access other health care services was also displayed to help patients access the services they needed, for example, dementia awareness and cancer support groups. The practice website contained a range of health promotion information for patients to access online, including questionnaires about depression, alcohol, asthma management and a pregnancy care planner. The practice referred expectant mothers to the NHS midwifery team and the GPs undertook post-natal and six week baby checks.

The practice offered and promoted a range of health monitoring checks for patients to attend on a regular basis. For example, cervical smear screening and general health checks including weight and blood pressure monitoring. We spoke with nursing staff who conducted various clinics for long-term conditions and they described how they explained the benefits of healthy lifestyle choices to patients with long-term conditions such as diabetes, asthma and coronary heart disease. All new patients who registered with the practice were offered a consultation to assess their health care needs and to identify any concerns or risk factors that were followed-up by the GPs.

The practice had systems to identify patients who required additional support and were pro-active in offering additional services for specific patient groups. For example, vaccination clinics were promoted and held at the practice, including a seasonal influenza vaccination for older people and those with chronic / complex needs. The practice also provided annual mental health reviews for those patients identified with mental health issues.

The practice carried out a full range of immunisations for children, as well as travel vaccines. The available data showed that all childhood immunisation indicators were higher than the local averages. For example, the MMR vaccination rate for the practice was 96%, compared to the local average of 91%. The practice offered sexual health screening for young people, for example, chlamydia testing.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice in relation to patient satisfaction. Information from the national patient survey showed that the practice had been rated below the national average in some areas, although in other areas the practice had been rated above the national average. For example, 95% of patients rated the practice nurses as good or very good in treating them with care and concern, compared with 90% nationally.

Patients completed comment cards to provide us with feedback on the practice. We received 46 completed cards and they were all positive about the service experienced. Patients commented that the practice offered an excellent service, that all staff were helpful, caring and respectful. We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected, although there were some comments in relation to difficulties in getting through to the practice on the telephone in the mornings to make appointments. Reception staff were welcoming to patients, were respectful in their manner and showed a willingness to help and support patients with their requests.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consultation and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The practice had a confidentiality policy, which detailed how staff protected patients' confidentiality and personal information. Staff we spoke with described how they followed the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Staff were aware of their responsibilities in maintaining patient confidentiality and the policy had been shared with them. The reception area was limited in the space available for patients waiting for their appointments, and may have sometimes made it difficult to prevent conversations being overheard. The practice had considered ways of making improvements, for example, a notice was displayed requesting that only one patient at a time approached the reception desk, to improve privacy and help maintain confidentiality.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed there had been a positive response from patients to questions about their involvement in planning and making decisions in relation to their care. For example, data from the national patient survey showed that 88% of respondents said nurses were good or very good at involving them in decisions about their care, compared to the national average of 85%. However, the data was less positive for GPs, where 76% of respondents said that GPs were good or very good at involving them in decisions about their care, compared to the national average of 82%. The results from the practice's own patient survey showed a positive response in relation to general questions about involvement in care and treatment and benchmarking data indicated patient satisfaction was higher by comparison to other similar practices.

When we spoke with patients, they told us they felt involved in decision making and were given the time and information by the practice to make informed decisions about their care and treatment. They said GPs and nurses took the time to listen and explained all the treatment options and that they felt included in their consultations. They felt able to ask questions and never felt rushed. Patient feedback from the comment cards we received was also very positive and was consistent with these views.

Patient/carer support to cope emotionally with care and treatment

We observed that staff were supportive in their manner and approach towards patients. Patients told us that staff gave them the help they needed and that they felt able to discuss any concerns or worries they had.

Patient information leaflets, posters and notices were displayed that provided contact details for specialist groups offering emotional and confidential support to patients and carers. For example, counselling sessions that were offered at the practice. The practice's electronic patient records system alerted GPs if a patient was also a

Good

Are services caring?

carer. There was a range of information available for carers to help ensure they understood the various avenues of support available to them. The practice website contained advice and information in relation to bereavement support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patient's needs. The staff we spoke with explained that a range of services were available to support and meet the needs of different patient groups and that there were systems to identify patients' needs and refer them to other services and support if required. For example, referring mothers with babies and young children to the community health visitor and older patients to specialist groups who supported people with dementia and associated physical problems. Patients we spoke with told us they were referred promptly to other services for treatment and test results were available quickly.

The practice engaged with other local practices to plan and develop services that reflected the needs of the local patient population. For example, the development of the community nursing 'over 75' team who operated a rapid response system to older patients referred for urgent care or assistance.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. The patient participation group (PPG) had recently formed and future meetings were planned. However, the practice had acted on the results of a previous patient survey, where feedback had indicated that there were sometimes difficulties in getting through to the practice on the telephone to make appointments. As a result, the practice had implemented online appointment bookings, online prescription requests and an additional telephone line dedicated to internal calls from other health care agencies and providers, to free-up the remaining telephone lines for patient access.

Tackling inequity and promoting equality

The practice was located in premises that met the needs of patients with disabilities and there was level access to the treatment and consultation rooms. The waiting area was large enough to accommodate patients with wheelchairs and prams and accessible toilet facilities were available for all patients attending the practice. There was a play area for younger children and a hearing loop system for patients who had hearing difficulties. Interpretation services were available by arrangement for patients who did not speak English and GPs at the practice also spoke a number of languages, including Swahili, Urdu and Hindi. The practice website also provided information in a range of languages. There were car parking facilities with disabled parking areas close to the building.

The practice took account of the needs of different patients in promoting equality. The majority of staff had received equality and diversity training and were able to demonstrate an awareness of the needs of different patient groups. For example, identifying those patients with learning disabilities to help ensure they received appropriate care and support, including an annual assessment of their health care needs.

Access to the service

Appointments were available from 8.00am to 6.30pm each week day and the practice operated extended opening hours from 7.30am on Friday mornings and until 7.30pm on Monday evenings. This provided flexibility for working patients outside of core working hours and school hours for children.

The practice had reviewed and adjusted its appointment system to maximise and improve access to GP appointments to help meet demands, including initiatives to reduce the number of missed appointments. An electronic messaging reminder service had been introduced that sent reminder text messages to patients to help them remember to attend appointments.

Patients could book an appointment by telephone, online or in person. Patients we spoke with said that the appointments system worked well. They said telephone consultations were available and that the GPs were very good at calling them back if requested. The GPs we spoke with confirmed that same day telephone consultations were offered to patients and this was managed via the patient records system. Pre-bookable appointments were also available and home visits were arranged for those who found it difficult to attend the practice, for example, older patients who were housebound. The practice supported a local care home for older people and a named GP visited residents on a weekly basis, and when required. Longer appointments were available for patients who needed them, for example, if they had long-term conditions or complex health care needs.

Patients we spoke with all expressed confidence that urgent problems or medical emergencies would be dealt with promptly, that staff knew how to prioritise

appointments for them and that they would be seen the same day. The staff we spoke with had a clear understanding of the triage system to prioritise how patients received treatment. For example, the practice had a system to identify and prioritise patients with poor mental health who required urgent access to a GP appointment, to access emergency psychiatric support for patients suffering mental health crisis.

There were arrangements to help ensure patients could access urgent or emergency treatment when the practice was closed. Information about the 'out of hours' service was displayed inside and outside the practice and was also included in the patient information booklet and on the practice website. A telephone message informed patients how to access services if they telephoned the practice when it was closed. Patients we spoke with told us that they knew how to obtain urgent treatment when the practice was closed.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. There was a complaints policy and a procedure that was in line with NHS guidance for GPs and there was a designated responsible person who handled all complaints in the practice.

Information was available to help patients understand the complaints system. The complaints procedure was included in the practice information booklet, on the practice website, and was displayed in the patient waiting / reception area. There were also questionnaires for patients' to complete to provide comments and feedback to the practice. We looked at two complaints that had been received in the last year and found that these had been satisfactorily handled and dealt with in a timely way and in accordance with the practice policy. Apologies had been offered to patients on both occasions.

The practice had produced a summary report of the complaints received for the previous year and identified where changes had been made as a result of some of the complaints received. For example, additional customer care training for reception staff and the introduction of the electronic messaging reminder service to improve communication with patients regarding their appointment times.

Patients we spoke with told us that they had never had cause to complain but knew there was information available about how and who to complain to, should they wish to do so.

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

The practice had a statement of purpose, which set out the aims and objectives of the practice, which were to provide good quality care and treatment for the patients who used its services. When speaking with staff, it was clear that the leadership / management team promoted a collaborative and inclusive approach to achieve its purpose of providing good quality care to all patients.

Staff told us they understood their roles and responsibilities in helping to ensure the practice achieved its aims and objectives and felt they contributed to the overall quality of care that patients received.

Governance arrangements

The practice had a clear leadership structure with named members of staff in lead roles. For example, there was a lead GP for safeguarding and a lead nurse for infection control. A GP also took a lead role in dementia and services for older people. We spoke with six members of staff who were clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns or issues.

The practice had a structured programme of meetings, including weekly clinical and governance / practice meetings that included discussions about significant events, medicines management, staff training and recruitment. These meetings also included the 'over 75' specialist nursing team if specific patients or issues required discussion. The practice also held monthly multi-disciplinary meetings with other care providers and specialists, for example, social services, community nurses and the palliative care team. There were bi-monthly team meetings for all staff to attend.

A member of staff was responsible for collating information and analysis of the Quality and Outcomes Framework (QOF) and this was reviewed to enable the practice to monitor on-going performance. QOF data indicated that the practice was performing either in line or above national standards in most areas and follow-up actions for improvement were discussed and agreed in practice meetings.

The practice had undertaken clinical audits to monitor quality and systems to identify where action should be taken to improve outcomes for patients. For example, an audit had been undertaken to review anti-biotic medicine prescribing following national recommendations and guidelines. A follow-up audit had found a reduction in prescribing for specific types of anti-biotic medicines over a 20 month period.

The practice had a number of policies and procedures to govern activity and these were available on the computer and in hard copy files for staff guidance and reference. We looked at ten of these and saw that they had been reviewed annually and were up to date.

The practice had arrangements for identifying, recording and managing risks in relation to the premises and its staff. Routine checks were undertaken and any risks were identified and recorded. Risk assessments had been undertaken, for example, a fire risk assessment. The practice had also undertaken an overall risk audit for governance purposes, which included processes / procedures in relation to patient safety, and general management of the practice.

The practice was involved in a local peer review process with neighbouring GP practices. The meeting notes and action plan showed that the practice had a set of agreed actions to help reduce the number of patients attending the local hospital accident and emergency department and the number of referrals to secondary care. Actions included increased multi-disciplinary working to improve support to patients in the community.

Leadership, openness and transparency

Meetings were held regularly and we spoke with the practice GPs who told us they advocated and encouraged an open and transparent approach in managing the practice and leading the staff team. Staff we spoke with told us they felt the GPs were approachable, they felt supported and were able to approach the senior staff with any concerns they had. All staff said they felt their views and opinions were valued and that they were encouraged to speak openly to all staff members about issues or ways that they could improve the services provided to patients.

The practice had a staff handbook, which contained a range of human resource policies and procedures to support staff, for example, sickness absence, bullying and harassment procedures. Staff we spoke with knew where to find these policies if required.

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through the national patient survey, as well as comments and complaints received by the practice. Results from the patient survey demonstrated that key areas for improvement had been identified, for example, getting through to the practice on the telephone and making appointments. As a result, the practice had planned and implemented actions. This included a review of the telephone system to introduce dedicated internal lines for health care professionals to use, leaving the external lines free for patient use. The practice had also introduced an online appointments system to help reduce telephone calls to the practice.

The practice had a patient participation group (PPG) that had recently become active and an initial meeting had been held, where patient feedback and suggestions had been discussed and actions agreed, which the practice had implemented. For example, the introduction of staff photographs that were displayed in the reception area and name badges for all staff to wear. PPG meetings were scheduled on a quarterly basis for the remainder of the year. We spoke with PPG representatives, who told us that they aimed to increase their membership to include a wider representation from all patient population groups, for example, younger / working age patients.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example, staff we spoke with told us they had expressed concerns about the increased workload and the practice management had agreed to employ additional administration staff. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. There had also been some comments from staff and patients about the design of the reception desk and how it was sometimes difficult to keep conversations private. The practice had responded by submitting a bid to the clinical commissioning group (CCG) to fund alterations to improve the reception area.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and information cards had been printed and given out to staff, who had signed to confirm receipt.

Management lead through learning and improvement

Staff told us that the practice supported them to access on-going learning to improve their skills and competencies. For example, update training for diabetes, childhood immunisations and vaccinations. Staff said they had dedicated time set aside for learning and development, for example, monthly half-day closure of the practice to undertake training and development. One member of the administration staff team told us they had recently requested additional training to expand their skills and this had been agreed. Formal appraisals were undertaken to monitor and review performance, and to identify training requirements.

The practice regularly reviewed significant events and other incidents and shared them with staff to help ensure learning points were recognised and acted on, to improve outcomes for patients.